PRINTED: 12/16/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION (X3) DA		
AND PLAN OF CORRECTION IDENTIFICATION NUMB  15G238		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED 11/22/2011
		15G256	B. WING		11/22/2011
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
OCCAZIO	) INC			ILEY RD ASTLE, IN47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0000					
	A Life Safety C	ode Recertification Survey	K0000		
	•	by the Indiana State	Rooo		
		Health in accordance with			
	42 CFR 483.470				
	42 CTR 465.470	)()).			
	Survey Date: 1	1/22/11			
	Facility Number	r: 000761			
	Provider Number				
	AIM Number:				
		10020			
	Surveyor: Mark	Bugni, Life Safety Code			
	Specialist				
	<b>.</b>				
	At this Life Safe	ety Code survey, Occazio			
		not in compliance with			
		or Participation in			
	•	FR Subpart 483.470(j),			
		Fire and the 2000 edition			
	of the National l				
		FPA) 101, Life Safety			
	,	apter 33, Existing			
		rd and Care Occupancies.			
	Residential Doa	ru and Care Occupancies.			
	This one story fa	acility was fully			
	<del>-</del>	e facility has a fire alarm			
	-	oke detection in the			
	-	ommon living areas. The			
		C			
		pacity of 8 and had a			
	census of 8 at th	e time of this survey.			
	Calculation of the	he Evacuation Difficulty			
LAROPATOR		OVIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	<u> </u> TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NYQ821

Facility ID:

000761

If continuation sheet

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G238		LDING	NSTRUCTION  01	(X3) DATE COMPL 11/22/2	ETED
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LEY RD		
OCCAZIO INC			NEW CASTLE, IN47362				
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	COMPLETION
TAG		using NFPA 101A,		IAG			DATE
	, ,	roaches to Life Safety,					
		the facility Prompt with					
	an E-Score of 1.0.						
		Robert Booher, Life Safety					
	Code Specialist-Me	edical Surveyor on 11/28/11.					
	The facility was	found not in compliance					
	-	entioned regulatory					
	requirements as evidenced by the following:						
	lollowing:						

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G238	A. BUILI	DING	otruction 01	(X3) DATE S COMPL 11/22/20	ETED
		100200	B. WING			1 1/22/20	711
NAME OF PROVIDER OR SUPPLIER  OCCAZIO INC			STREET ADDRESS, CITY, STATE, ZIP CODE  1803 RILEY RD  NEW CASTLE, IN47362				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		1	ID	1		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DEFICIENCY)	
KS053	accordance with 9 powered from the and when activate audible in all sleep are installed on all basements but excunfinished attics. A installed for living and similar spaces  Exception No 1: B throughout by an a	cluding crawl spaces and Additional smoke alarms are rooms, dens, day rooms, s. 33.2.3.4.3.  uildings protected approved automatic					
	that uses quick res sprinklers, and pro smoke alarms inst in accordance with	n accordance with 33.2.3.5, sponse or residential stected with approved alled in each sleeping room n 9.6.2.10, that are powered electrical system.					
	protected througher automatic sprinkle with 32.3.2.5, that residential sprinkle battery-powered s sleeping room, and the authority havin has demonstrated and a battery repla	Where buildings are but by an approved r system, in accordance uses quick-response or ers, with existing moke alarms in each d where, in the opinion of g jurisdiction, the facility that testing, maintenance, accement program ensure wer to smoke alarms.					
		acility failed to moke detectors was ere airflow could	KS	)53	Occazio, Inc. 1803 Riley Road, New Castle Survey Completed 11/22/20 Survey Event ID NYQ821 15G238		12/22/2011
	NFPA 72, Natio	9.6.2.10.1 refers to nal Fire Alarm 2, 2–3.5.1 requires,			K0053 Life Safety Code Standard The facility failed to ensure all of 8 smoke detectors were	II 1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  O1		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION		15G238		LDING	<u> </u>	11/22/2	
		100200	B. WIN		ADDRESS CITY STATE TID CODE	1 1/22/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
OCCAZI	O INC		1803 RILEY RD NEW CASTLE, IN47362				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	installed in a location which w		DATE
	-	ed by air handling			allow the smoke detector to		
	I -	tors shall not be		function to its fullest capability.		tv.	
	located where	airflow prevents				., .	
	operation of th	e detectors. This			1. What corrective action	า	
	deficient pract	ice could affect all			will be accomplished?		
	clients in the fa	acility who use the			Koorsen will relocate	to 0	
	living room.	•			smoke detector in the home location that is at least 3 feet		
					away from an air diffuser.	•	
	   Findings includ	de:		and, nom an amadon.			
	Based on observation on 11/22/11 at 9:15 a.m. with the area residential coordinator, the living room smoke detector was mounted one foot from a supply air duct. This was verified by the area residential coordinator at the time of observation.				2. How will we identify o		
				residents having the pote			
					to be affected by the same		
					deficient practice and what corrective action will be tak		
					· All clients would have the		
					potential to be affected		
					3. What measures will be		
				put into place or what systemic			
					changes will be made to ensure that the deficient		
					practice does not recur?		
					Residential Coordinate	or will	
					monitor		
					· Director of Residential		
					Services will monitor	ator	
					Maintenance Coordina     will monitor	atOI	
					4. How will the corrective	е	
					action be monitored to ens		
					the deficient practice will no	ot	
					recur?  Residential Coordinate	or will	
					monitor	JI WIII	
					· Director of Residential		
					Services will monitor		
					· Maintenance Coordina	ator	
					will monitor		

000761

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 11/22/2011	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
OCCAZIO	O INC			ILEY RD ASTLE, IN47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				5. What is the date by w the systemic changes will I completed? · 12/22/2011	
				Respectfully submitted,	
				Rosemary Taylor, Director o Operations	f